North Carolina Department of Health and Human Services

Division of Health Benefits

Topical Local Anesthetics (Lidoderm Patch, lidocaine patch, and ZT Lido)

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: ___Lidoderm Patch ___lidocaine patch (generic) ___ZT Lido

9. Quantity per 30 days_____9a. Length of Therapy_____

1. Does the beneficiary have a diagnosis of Post-Herpetic Neuralgia? ___YES ___NO
2. Does the beneficiary have a diagnosis of Neuropathic Pain? ___YES ___NO
   - 2a. Has the beneficiary tried duloxetine and gabapentin? ___YES ___NO
   - 2b. Does the beneficiary have a previous documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressants, SSRI's, SNRI's, anticonvulsants, NSAID's or COXII's? ___YES ___NO
     List drugs tried:_____
3. Does the beneficiary have a diagnosis of Chronic Musculo-Skeletal Pain of greater than 6 months in duration? ___YES ___NO
   - 3a. Does the beneficiary have a previous documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressants, SSRI's, SNRI's, anticonvulsants, NSAID's or COXII's? ___YES ___NO
     List drugs tried:_____
4. Is the prescribed dose within the FDA recommended maximum amount of 3 patches per day and no more than 90 patches per month? ___YES ___NO

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

DMA-3104